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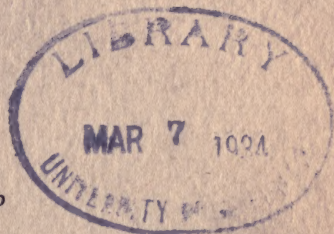
Vol. IX

Bulletin

OF THE

Ontario Hospitals for the Insane

*A Journal Devoted
to the interests of
Psychiatry in Ontario*



Printed by Order of the Legislative Assembly



FOR THE DEPARTMENT OF THE PROVINCIAL SECRETARY.

Printed by A. T. WILGESS, Printer to the King's Most
Excellent Majesty.

Every medical practitioner in Ontario is invited to interest himself in the success of the Hospital for the Insane in the district in which he resides. Every Superintendent realizes that the successful results aimed at in the modern treatment of the insane can be more readily secured by enlisting the co-operation and sympathetic support of the medical men who were formerly the physicians to the patients in their homes. The family Physician naturally watches with interest the course of the hospital treatment and should consider himself an honorary member of the visiting staff of the hospital to which his patients are sent for treatment.

PROCEDURE TO SECURE ADMISSION OF PATIENTS.

The Provincial Secretary desires that all cases that are likely to be benefited by treatment in a Hospital for the Insane should be admitted with the least possible delay.

(1) Where the property of a patient is sufficient, or his friends are willing to pay the cost of the Medical Examination, the family Physician should apply directly to the Medical Superintendent of the Hospital for the Insane, in whose district the patient resides, for the necessary blank forms. These being secured, they should be properly and fully filled in, dated, signed in presence of two witnesses by the medical men in attendance. They are then returned to the Hospital, and if satisfactory, and there is accommodation, advice will be sent at once to have the patient transferred.

(2) Where the patient has no property, and no friends willing to pay the cost, application should be made to the head of the Municipality where he lives, who, after satisfying himself that the patient is destitute, may order the examination to be made by two physicians, and a similar course to the above is then followed. The Council of the Municipality is liable for all costs incurred, including expenses of travel.

(3) Where the patient is suspected to be dangerously insane, information should be laid before a magistrate, who may issue a warrant for the apprehension of the patient and if satisfied that he is dangerously insane, may commit the patient to the custody of someone who will care for him, but not to a lock-up, gaol, prison or reformatory, and notify the Medical Examiners. The Magistrate should then send to the Inspector of Prisons and Public Charities, Parliament Buildings, Toronto, all the information, evidence and certificates of insanity. The costs incurred by this method form a charge against the County, City or Town in which such patient resided.

Voluntary Admission.

The Superintendent of a Hospital for Insane may receive and detain as a patient any person suitable for care and treatment who voluntarily makes written application on a prescribed form, and whose mental condition is such as to render him competent to make application.

A person so received shall not be detained more than five days after having given notice in writing of his desire to leave the hospital.



DR. R. W. BRUCE SMITH

Deceased March 28, 1916

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The Bulletin

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In Memoriam

As the BULLETIN goes to press we are shocked by the sad news of the decease of its Author and Editor—Dr. R. W. Bruce Smith. The end came peacefully to the Doctor, while in his home surrounded by his family, at five o'clock on Tuesday morning, the 28th of March, after an illness of more than a year's duration.

Dr. Smith was born in Mitchell on the 11th of May, 1857, being the son of a Methodist clergyman. He entered Victoria University as an Arts student, but before completing this course he took up the study of medicine, graduating from Toronto University in 1878. He practised as a physician in the Town of Seaforth for fifteen years, and in 1894 was elected President of the Ontario Medical Association. The same year he received the appointment of Assistant Physician in the Hospital for Insane, Hamilton, from the Ontario Government, being resident at "Orchard House." Some six years later he was promoted to the position of Assistant Superintendent in the Eastern Hospital for Insane, Brockville, and in 1904 was appointed Inspector of Hospitals and Public Charities. This opened up a new field for Dr. Smith's usefulness, and one in which he became very widely known and most highly respected throughout the Province of Ontario. He sought in a practical way to promote the interests of the people generally in charitable

institutions. He always had a sympathy for those engaged in the management of the hospitals, and encouraged every effort on their part tending to the betterment of the patient. He was broad in his outlook, and in every possible field he sought information, both from personal contact with these institutions, and from various magazines bearing on hospital administration from abroad. Where these innovations would be helpful in Ontario he adopted them.

Although leaving the field of mental diseases practically in 1904, he maintained his interest in the Provincial mental hospitals, and his assistance was often sought in this department. In the introduction of the Training Schools for these hospitals, and their organization on a Provincial basis Doctor Smith lent a very helpful hand. He recognized the importance of the trained nurse in the adoption of true hospital methods for the care of the mentally sick. He was appointed Chairman of the Examining Board for the mental nurses, a position which he held up to the time of his decease.

Another important field of Doctor Smith's work was centred in the editing of the BULLETIN. This little publication was one of his hobbies, and where he found that a medical officer was doing a bit of original research in a quiet way the Doctor would suggest that an article along these lines would be welcomed in the BULLETIN.

Dr. Bruce Smith had a wide, wholesome sympathy for the individual sufferer, and in every sphere in which his official life lay he was ready to extend a helpful hand and give words of encouragement. He was never more pleased than when he could recommend an appointment or promotion to some honest worker in his service. In a true sense he was humanitarian, and his work leaves a grateful memory in the hearts of many people in Ontario.

LITIGIOUS OR QUERULOUS PARANOIA

BY JOHN WEBSTER, M.B.,

Assistant Physician, Hospital for Insane, Hamilton.

A litigious form of insanity has long been recognized. Sir Walter Scott, in "Red Gauntlet," portrays, in the character of poor Peter Peebles, a typical case drawn from real examples known to him, and who flourished and haunted the courts of justice in Scotland about the year 1792. In the novel, the old lawyer, Mr. Latimer, is made to say to his son, "You must have seen this original, Darsie, who, like others in the same predicament, continues to haunt the courts of justice where he has made shipwreck of time, means and understanding. Such insane paupers, etc."

This form of insanity, first specifically described and classified by Hitzig, in 1895, is now generally grouped with the paranoias.

Berkley describes such cases as "Ethical Imbeciles." Kræpelin sees in the condition a manifestation of degeneracy, while Diefendorf recognizes two forms of the disease—the Querulent and the Pseudoquerulent—the former, a true paranoia, where the delusions, perhaps based on some real injustice, are enlarged, systematized and exploited persistently regardless of consequences, the rights of others and to the exclusion of everything else; the latter a psychopathic condition developing on a morbid constitutional state, where the querulent delusions, such as they are, are unstable, changing and unsystematized.

In discussing the anomalies of the instincts, Tansy writes: "From the clinical point of view the most re-

markable product of the exaggeration to which the instinct of property, always very strong, is liable, is the so-called querulent delusion. The querulents or processomaniacs, notwithstanding the fact that they have good intelligence, and complete lucidity, are so infatuated and devoid of moderation in the judgment of their own interests, that they are unable to recognize the limitations imposed by the interests of others and the precise terms of the law and interpreting the law in entire good faith, but with all sorts of cavils, they plunge into ruinous and endless litigation."

"This delusion, which constitutes a variety of paranoia, continues for years in a latent state; but in time its progressive character impels the patient to litigious actions. . . . Incomplete or occasional processomania occurs also, apart from paranoia, in maniacs, especially in the periodic form of mania, the rapid disappearance and repeated interruption of the mania prevent the development of the delusion throughout the long stages of judicial procedure."

In other forms of paranoia where the patient has been deprived of his liberty, the querulent delusion almost invariably develops in a greater or less degree, and is responsible for the frequent actions for damages, taken by such patients, for false imprisonment.

Litigious paranoia usually manifests itself about the middle period of life, with a gradual development, perhaps extending over several years. As a rule, the family history of the patient shows a decidedly neurotic taint. The patient, himself, previous to the development of the disease, may have been considered of good intelligence, but more often he has been known as eccentric, egotistical, incompetent, or a failure.

As a result of his incompetency, perhaps, he experiences financial reverses, or it may be he has actually been swindled or maligned. The instinct to fight for his rights and reputation is aroused and, if possible, he ap-

peals to the law for reparation, but in any case, the querulous attitude becomes prominent and persecutory delusions spring to life.

At this time, he is not considered insane, and has many friends and sympathizers, who encourage him in his course. Failing in his legal action, he appeals the case despite the expense and the fact that it has been shewn no legal grounds for action exist. Added decisions against him only stimulate him to further appeals. His case occupies his whole time, thought and conversation to the utter neglect of his business, and his repeated failures develop in him the belief that he is the victim of a conspiracy in which the courts are in league with his enemies. The original case may be lost sight of in the ever-increasing range of the plot. He fails to see any but his own point of view, shows no insight or consideration for the rights of others, becomes a nuisance to the community and perhaps estranged from his family and friends. He is uncompromising, irritable and in "an attitude of hostility to society and the powers that be" (Tansi). He may take the law in his own hands and do violence to life or property, or develop the delusion that his own life is in jeopardy at the hands of his enemies and make specific charges. We now have the picture of the *persecuting persecuted*. A gradual mental deterioration takes place without clouding of consciousness or loss of memory, although the latter is often colored by his delusions. Hallucinations are seldom present in the course of the disease and true expansive delusions do not develop although there is extreme egotism and self-confidence. Only a proportion of such cases reach our Hospitals and such as eventually require institutional care invariably include the hospital authorities with their enemies.

The prognosis in this form of mental disease is not good. Seldom, if ever, does the patient completely renounce his delusions. He may continue in open hostility

to all authority, or brood over his wrongs in silence, only occasionally giving vent to his feelings in outbreaks of irritability and abuse. Sometimes the patient is quite tractable and contents himself with writing long letters to various persons in authority, often in pseudo-legal form, for most imagine they have a knowledge of the law and legal procedure. "Their letters are long, carefully written, usually on a particular kind of paper and sometimes written with colored ink" (Diefendorf). Only occasionally may one so afflicted, force his delusions to the background for a time, but sooner or later, they almost invariably become prominent again.

Following are brief extracts from the case books of two of our patients:—

R. T. A.—Admitted Feb. 12th, 1908, aged 56 years.

FAMILY HISTORY.

Parents were "peculiar." One brother hung himself while an inmate of an asylum; another is a blind imbecile, while others are decidedly eccentric.

PERSONAL HISTORY.

Born on a farm, patient has followed farming all his life. He has always been considered "peculiar" and on several occasions has walked in his sleep. At school he was stupid and made poor progress. As a farmer he was inefficient and never got on, although ambitious, temperate and industrious. He inherited a farm when thirty years of age, but soon had to place a mortgage on it. He married when thirty-three years of age and, after four years of married life, having no children, he adopted an English boy, later adopting the whole family, six in all.

When admitted to this hospital, decided mental symptoms had existed for several years and appear to have

originated from constant financial difficulties, especially in connection with the mortgage on his farm, which after 18 years, he had been unable to reduce. He claimed he had not been credited with interest paid, and later that the mortgage had been altered, notwithstanding that said mortgage was registered and deposited with the County Registrar and that he was allowed to examine it. He developed the idea of a conspiracy against himself in which various lawyers and officials were connected, neglected his work, became irritable, and estranged from his wife, who, on two occasions, was forced to separate from him. He haunted the offices of various lawyers, threatened lawsuits and became a nuisance in the community. Hearing some shots fired, he believed that an attempt had been made on his life.

When eventually the mortgage was foreclosed and a sale of his chattels advertised, patient set fire to his barns to prevent others acquiring his stock. This led to his arrest, but being found insane, he was transferred to this hospital.

During his six years' residence here, his attitude towards his delusions has not changed, and he still nurses the idea of obtaining redress for his alleged wrongs. He tells a coherent, well-elaborated story, is usually quiet and composed, but occasionally has outbreaks of passion when he threatens all implicated in his financial difficulties and "imprisonment."

Occasionally, he takes a saner view, and decides to accept his losses and leave the country, but he is unable to adhere to this resolve, and in a few hours has reverted to his former querulous attitude.

In this case the patient's constitutional mental deficiency was responsible for his failure in life. Failing to appreciate the true cause, querulent and persecutory delusions followed as a natural sequence.

Case 2.

T. L.—Admitted to this Hospital 26 years ago, at the age of 40 years. Others of the family connection are in institutions for the insane. The history of the psychosis shows nothing out of the ordinary in such cases. An imagined injury, efforts to obtain redress, ending in his forcibly claiming what he considered his own. He is a man of poor education, but of good intelligence and ability.

After 26 years' residence here, patient still uncompromisingly follows the litigious road. He is very stubborn, but if not interfered with is easily controlled. His whole time is devoted to writing "legal documents," of which he has issued hundreds, all carefully written with a special ink made by himself, with many flourishes, an excessive use of capital letters, but without punctuation marks. They are of uniform size, beautifully bound and enclosed in an envelope of his own manufacture.

The following is a brief extract from one of these:—

PAPERS NUMBER 212 IN EVIDENCE.

Tuesday October 15th 1912

Hamilton Lunatic Asylum

Mr. F. L. Sr., I, T. L., Sr. Writes you any my Brothers In The United States or In The State of Michigan Tuscola County Upon The Alleged business of My Injunction of May Thursday 20th 1907 And The One Of The Date of March Monday 4th 1907 And I Said Plaintiff Sends to you This Written Statement And Order you And C. L. W. and Mr. A. D. W. and I Said Plaintiff Wants you And Them As Agents to Place My Alleged Affidavit or My Alleged Writ of Controversy Into the Supreme Court in The State of Michigan And I Sue to Prosecute In Law to Make Legal Claim to Where This Alleged Writ of Controversy is Taken In behalf of Said Plaintiff Alleged Affidavit or Said Trover Action of the Date of October Tuesday 26th 1909 And being Papers 774 And In Behalf of My Writ of Controversy of The Date of Tuesday February 15th 1910 And being Papers Number 993 And Whereas This Alleged Writ of Controversy Which I Said Plaintiff Send to you Which is Marked Number 994 On the Top Page is to Go Into the United States Supreme Court And to be Re-entered Into Canada Supreme

Court In the Town of Simcoe And A Copy is to be Filed Into The Norfolk Country Registry Office As Said Plaintiff Writ of Controversy is A Lisdendance Against the Crown or Public Lands And This Trover Action is Taken Against Said Canada Governments and Said Defendants Indecent Immoral Seditious Disloyal Scurrilous or Libelous Political Character to Where The Said Canada Governments Political Schemes is Devised And Intended to Deceive And Defraud The Public For the Purpose of obtaining Money Under False Pretences Misdemeanor And is A Fraud to Defraud Said Plaintiff by the Said Canada Governments Obstructing Said Plaintiff Rights of The Said Laws And Highways And to Where The Said Laws is The Right of Highways And Whereas The Indemnity of Fines Which is Imposed by Said Laws is a Security Against Loss or Penalty A Compensation to Recompense Said Plaintiff For the Wrong And Injustice or Injury Which has been Dun to Said Plaintiff and The Laws Now I Will Undermention Article 18 Obtaining Money Valuable Security or Goods by False Pretences Receiving Any Money Valuable Security or Other Property Knowing The Same to have been Stolen or Unlawfully obtained; And Whereas I Said Plaintiff Will Refer To The Combination Which Took Place At The Asylum On January 6th 1902 When I Said Plaintiff Was Robbed With Violence by The Asylum Staff And on March Monday 18th 1912 The Asylum Employees Wanted Said Plaintiff to Except The Stolen Thirteen Dollars \$13. And I Said Plaintiff Refuses Upon The Bases Of The Laws And I Send to you My Writ of Controversy to be Placed Into The Court to Settle The Question.

A CASE OF PARESIS WITH PARANOIDAL
DELUSIONS.

BY GERALD H. J. PEARSON, A.B., M.D.,

Assistant Physician, Hospital for the Insane,
Mimico, Ont.

Paresis may be defined as a chronic psychosis of middle life, characterized mentally by progressive deterioration leading to absolute dementia, and physically by typical signs. The symptomatology is fairly definite. There is an increasing difficulty of apprehension of external stimuli. The attention is maintained with an effort and clouding of consciousness rapidly develops. If hallucinations or illusions appear they are feeble and play an unimportant part. As a result of the clouding of consciousness patients become disoriented in all spheres, but especially temporally. Memory defects are among the first to appear and are very noticeable throughout the course of the disease. Impressibility is affected early. This shows itself prominently in matters connected with time. Patients do not know when they had breakfast or when they last saw the doctor. Retentiveness is well maintained for some time, connected accounts of former life being obtainable but it eventually deteriorates, and here, also, the temporal element defects first. As memory fails its place is taken by the imagination and the invention runs riot with a great abundance of dream-like fabrications. The store of ideas is progressively impoverished. The ideas retained are not firmly grounded and fail to exert a lasting influence on the thoughts and actions. Any accidental impulse suffices to distract and lead them into other channels. Judgment becomes exceedingly de-

fective. The patient indulges in all manner of recklessness. Former successful conservative business standards are rejected and he rushes into risky speculations. All obstacles to his schemes are ignored. His moral sense is blunted and he enters upon a career of vice. Delusions are formed which, though varying much in different patients, are changeable, characterized by changeableness, absurdity, incoherence, instability and unsystematization. It only rarely happens that for short periods they are stable and uniform like those of paranoia. Insight may be present early, but soon disappears, and a feeling of well-being takes its place. The emotions are profoundly disturbed. At first there is a marked increase in irritability. The finer sensibilities deteriorate. Instability and abrupt changes are frequent. The patient may weep bitterly at one moment and the next laugh and declare he never felt better in his life. Volitionally there is hypersuggestibility. The disposition is profoundly altered and the conduct shows a striking disregard for law and order.

Paresis may be classified into five varieties. The demented form comprises 40 per cent. of admissions with a duration of life less than five years. Its characteristics are progressive deterioration without prominent delusions, hallucinations or psychomotor disturbance. The expansive form comprises 15 to 16 per cent., runs a course of about five years and is characterized, as its name implies, by a great wealth of exaggerated expansive delusions. The agitated form comprises 11 per cent., lasts less than two years and shows extremely expansive delusions, great psychomotor pressure of activity and extreme clouding of consciousness. The depressed form comprises 25 per cent. with an expectation of life of less than two years. This form onsets usually after forty years of age and is characterized by despondency and depressed delusions. Delusions of persecution with hallucinations of hearing may develop but are generally un-

stable and exaggerated. The consciousness is much clouded. The circular form combines the emotional states of exaltation and depression.

Bearing in mind the foregoing symptomatology the following case is of interest:

J. H. is a short, well-nourished, black-haired, blue-eyed Canadian of 37 years of age, with a pale, flabby face, showing some overaction of the muscles of expression, especially evident when talking. He slouches in walking and his gait shows some ataxia though not markedly. He sits at the window of the cottage most of the day reading the newspaper and positively refuses to do any work.

FAMILY HISTORY.

His father is alive and well at eighty years of age. His life has been free from abnormalities and his habits good except that he drinks a little. His mother is alive and well at seventy years of age. Patient has three sisters living and well. One sister dead in childbirth. Three brothers alive and well. One brother dead of pneumonia. No history of mental or nervous diseases or syphilis in the family is obtainable.

PERSONAL HISTORY.

Patient was born on a farm near a small Ontario town. He remembers little of his early life. On account of the distance to school and because he was required to assist at home he was unable to attend school till he was twelve years of age. From that time till he was eighteen he attended irregularly and reached the third reader. He considers this progress good, on account of the poorness of his opportunity. After leaving school he worked at home and with neighbours until he attained his twenty-third year. Then he went to Manitoba. He farmed near a small town in Manitoba for six weeks, then engaged in carpentry work in the town till harvest when

he returned to the farm. The following winter he spent at his trade in Winnipeg. In the summer he farmed once more, but that winter returned to Winnipeg permanently. In the spring of 1903 he opened a bicycle repair shop, at which he worked successfully for eight or nine years. As a result of undertaking some larger project he became insolvent, and shortly after left Winnipeg for Fort William, carpenter's work having been promised him. After a few weeks of work he was laid off and discontented with waiting he left Fort William and visited at his home for some months. Returning to Port Arthur he followed his trade until early in the winter of 1914.

Anamnesis.—The initial symptoms date back apparently for a number of years. Previous to his business failure he led rather a vicious life in Winnipeg. He told his sister that girls would come into his shop and entice him out. Presumably he spent considerable money in this manner. In the winter and early spring of 1910 he invested heavily in some wild-cat mining stock and lost much money. On account of this loss he became bankrupt and had to sell out his business. He engaged in his trade once more but lost position after position until in desperation he persuaded his sister to come to him from Chicago and in order to discover the reason of his failures to live under an assumed name. This she did at first, but soon found out that the trouble was subjective, not objective. He drank heavily. For a short time all seemed well, but he became suspicious of his sister, accused her of prostitution and immorality and said that their suite was a "dive." He forced her to move frequently to escape from the vicious surroundings. He found it impossible to hold a position. It was at this time she noticed some ataxia and also tremor of his hands. At last the foulness of the epithets he applied to her increased to such an extent that she refused to live with him. Part of the time his employment in Win-

nipeg had been that of a strikebreaker, and he evidently feared that he had incurred the enmity of the union so, after the disruption with his sister, he left Winnipeg and went to Port Arthur, accepting a position there. However, he asserts that the union telephoned there ahead of him, and when he arrived his fellow-workmen began to shun him and jeer at him. Each firm he worked with was the same. When one of his employers discharged him he believed it to be due to underhand work on the part of the union. When he left Port Arthur the trainmen acted strangely towards him, which he attributes to the fact that they were union men and he a "scab." Soon his persecutory delusions included the carpenters, trainhands, boarding-house-keepers and restaurants of Port Arthur. On his return from his visit home he again had trouble with his landlady, and states that a policeman ordered him to move at 10.30 p.m. and would give no reason for so doing. After much discussion he obeyed, but at the next boarding-house the first night he was assaulted by a Mr. Bell (whose homicidal attack he attributed to the fact that he was a member of the Barbers' Union). On complaining to the police the magistrate dismissed the charge, with the statement that the patient was crazy. As a consequence of the inability to secure police protection he commenced to carry a revolver. The people of Port Arthur now delighted in walking past his window at night and calling him vile names. Mr. Bell again attempted to assault him, and when he threatened him with his revolver he was arrested. At the trial his lawyers betrayed him and he was sentenced to the prison farm. The change in his surroundings allayed his delusions for a short time, but not for long. The other prisoners and the farm officials abused him and he, goaded by wrong that no one would redress, struck one of the former with a hammer. He was removed from the farm, and to cover the

crimes of the officials he says he was railroaded into the hospital for the insane. Again new conditions quieted his mental condition, but it was not long before the supervisor of the cottage was calling him the vilest of names and threatening to burn his father's house and barn if he betrayed him. His sister visited him on the 28th of April, and he threatened to do her bodily harm if she did not procure his release. On May 13th he stated that he had overheard the attendants saying that his sister had been to visit him and had been confined in the basement of the cottage. He had also heard her voice calling for help. Recently his delusions have extended to include the medical staff among his enemies.

Physical Status Praesens.—A well-nourished male of thirty-seven years of age. His face is expressionless and there is overaction of the facial muscles on attempting to talk. There is a tremor of the tongue and lids and of the extremities. His eyes react to accommodation but not to light. There are no ocular palsies. In the left nostril there is an ulcerated area that has partly perforated the septum. The right elbow and left knee are marked with large irregular scars, indicating probably some syphilitic condition in the past. The reflexes are markedly exaggerated, the right more than the left. There is a Babinski and a sustained ankle clonus. Romberg is positive. Speech is slurring and the handwriting shows the typical paretic tremor. The Wassermann is four plus positive.

Mental Status Praesens. Perception and Consciousness.—The reaction of the patient to present stimuli is good. His sight is good, his colour sense fair. His hearing is normal and his cutaneous sensibility undisturbed. He suffers from auditory hallucinations persecutory in character. These consist of jeers and mockery, vile epithets and threats of injury to himself and relatives. They are never addressed directly to the patient but

always only in his hearing. The other senses show no hallucinations or illusions.

Memory.—Retentiveness is excellent. He gives a coherent, connected account of his life and specifies dates for the various occurrences. These dates are mostly the correct ones as attested by corroborative information, but some, especially those concerning the time when his illness onsetted, are erroneous. Impressibility is undisturbed. He can give exact accounts of each day with the correct time assigned to each event.

Orientation.—He is oriented in all spheres, temporally, spatially, personally.

Thought.—His train of thought is coherent, connected and shows no abnormalities. The content is largely connected with his delusions, but at times he talks comprehensively on other topics.

Judgment.—Apart from the fact that he has no insight into his condition, his judgment for matters of general interest and pertaining to his environment is good. But once the subjects of his delusions are touched on he reacts. He had built up a vast framework of systematized persecutory delusions that at first involved only the carpenters' union, but since has spread until it embraces his relatives, the railway employees' union, the barbers' union, his employers in Port Arthur, the magistrates that committed him, the government officials, the medical profession, the legal profession and the supervisor and the attendants of the cottage in which he is confined.

Emotions.—It is in the emotional field that the patient betrays most symptoms that bespeak paresis. There is considerable deterioration. The patient is irritable, easily disturbed, sullen and peevish and quickly loses his self-control. There is marked instability. He has attacks of weeping, for which no cause may be found. He may at one time be depressed and at another be

elated. Though he has a sense of well-being his general attitude is one of suspicion and depression.

Attention and the volitional field are not disturbed.

There is little in the preceding mental history to indicate paresis. The definite auditory hallucinations, the practically unclouded consciousness, the well retained memory, the excellent temporal orientation, the marked persecutory delusions and the prolonged course point to a condition akin to dementia præcox of the paranoid type. But the emotional deterioration denotes paresis and the physical examination confirms our diagnosis. In the short resume of the disease-complex at the beginning of this paper the physical symptoms were omitted as too well recognized to need repeating and a short study of the physical status praesens of the patient reveal the fact that there are present nearly all the distinctive signs of dementia paralytica. On these grounds and with the confirmatory finding of a four plus positive Wassermann the diagnosis was made.

I desire to thank Doctor Beemer, Superintendent of this Hospital for permission to present this case and for invaluable assistance and advice in the composing of this paper.

AN AEROPLANE FLIGHT.

BY MAJOR C. L. McVICAR,

Pathologist and Clinical Director, Hospital for Insane,
Toronto.Now overseas with No. 4 Canadian General Military
Hospital (Univeristy of Toronto).

DEAR DR. FORSTER,—I have always had a curiosity concerning aeroplanes. I remember that about five years ago I went out to Weston to see DeLesseps fly from Weston over the City Hall and back. There was a great crowd and the impression created by the great bird-like machine was lasting. Since we have been on service we have seen a great deal of them. In Greece both the enemy planes and the French have visited us. Naturally we tried to satisfy our curiosity by visiting the aerodrome, and here we found the Commandant a dashing and courteous young Frenchman, very entertaining. He never tires of explaining his machines and of telling of his exploits. He has taken several of our officers up and to-day was my turn. But he was to-day entertaining a fellow-countryman of the Infantry, and as the day was fine he turned me over to a younger pilot. Young pilots are characterized by a great daring, which makes up for lack of experience, and they like to entertain a passenger. I had an entertaining ride.

One puts on a greatcoat, then a balaclava cap, then a cap that fastens securely under the chin. It is explained that nothing must blow away while the machine is aloft, because it might blow into the propeller. Then properly and warmly dressed, one climbs into the machine, step-

ping gingerly among the wires into the seat in front of the pilot. Here you strap yourself in and begin to feel like an observer. An assistant spins a propeller just like you crank a "Ford" and the juice is turned on to test the machine. The blocks that have restrained the machine are taken away and you are off. You skim along a piece of rising ground and at the top you find yourself in the air. For a few moments the buildings and landscape seem to rush behind you, and then more slowly as you mount. There is no unpleasant sensation. You see the country mapped out below you like a panoramic picture. Farms show up like squares on a checker-board; herds and flocks, tents and waggons, men and all things show up like specks—water courses scratch the surfaces of the mountains—lakes and villages are discerned beyond the mountains—trenches and roads and railways and rivers streak the flat picture, and you realize how pictures of a whole area may be made and shaded to show reliefs. (See *Graphic* of January 8th for Salonica and surroundings.) The wind is wonderful. The graceful bird-like machine whirls ahead with little sensation of rapid movement. The ships in the harbour look small in the distance. You look about and over the sides and feel confident that all is well. You have a careful pilot, a sound machine, and a great faith in science. You climb higher into the clouds, but there are no clouds. Below, other aeroplanes flit about as if afraid to venture higher. You are interested now in picking out familiar places. Here is Pernor, there is Yemkin—there is Graddora, here Sterna Galiko, there is the Vardar, here the Galiko—away to the right are the snow-capped mountains that look so high from the ground. Now you can see over them and catch sight of a ridge beyond. You look at your watch—ten minutes in the air—you remember that twenty minutes is quite a long pleasure flight—perhaps the pilot will soon want to go back. You wish he would go on for an hour so that

you might see more of the country. Then he turns gracefully about—nothing in that—it is easy.

Again he turns and resumes the old direction. He is a nice, careful sort of pilot.

Suddenly he starts something new. He has apparently gone crazy. A week ago you saw an aeroplane in the air that looked as though it had a crazy pilot—it made you hold your breath to watch him dive and turn. He seemed to stand on one end, then on the other, then he would shoot straight up, then dive down, and always when you expected him to overturn he righted himself and then took another dive. He was apparently showing off to the nurses, for he was above the camp and quite close to the ground, not that there is much difference in the result of a fall from 100 feet and 1,000—or even from 4,000—for that was where I was—and for ten minutes this pilot did all the stunts short of looping the loop, that I had ever seen or heard of. Sometimes the earth looked like a huge toboggan slide sloping away into infinity. Then you saw it heaped up in a mass on the other side. I reflected that he wasn't taking any chances with himself, and if he could stand it I would try, although it might take some time to get used to it. There was very little sensation of moving ahead through space. The machine seemed to stay in one place and stood first on one ear, then on the other, then on its tail, and then you rushed upwards into the ether, then its nose was turned down and suddenly you saw a hill in front of you rising for miles and miles. There were no handles to take hold of, your body was suspended now on one side, now on the other, about three-quarters of a mile or more above a nice looking doll's tea-set, which turned out to be a village. I found a strap after a while and hung on to it with one hand. There was a rifle in front of me and it started to dance round on the bottom of the car. So did a couple of cartridge clips.

I had on a pair of woollen gloves and I felt the palms

moist. The machine swooped a few more turns and I closed my eyes. I didn't need them open because I was not driving the car and didn't want to see things contorted. I took a look at my watch again, it was twenty minutes past four and the gyrations had commenced at ten past four. Things became quieter. The pilot had evidently found out that the strap was keeping me in all right, so he started in a straight direction and I began to pick up known objects in the landscape again. They were fantastic in appearance, like the dream of the rarebit fiend, but a little endeavour enabled me to recognize them. A cluster of tents over there was where our Hospital should be, and there was the road running like a white string beside it. After that the descent was uneventful, we circled round several times to get low enough to land. I could see someone holding a horse and noted that it was not mine because it was not the right color—khaki and blue became distinguishable—a dog could be seen running round. The railway looked like the old markings we used to put on our maps and, finally, after half an hour in the air, I put my feet on the ground again and my first experience in an aeroplane was over. I couldn't look a gift horse in the mouth so I shook hands with the pilot and thanked him. That was all the French I could muster. I could not go into details to tell him that I was thanking him less for the ride than for getting me safely back again. But I would have been sorry to miss the experience, and I am satisfied. I am a married man and I am not going up again, unless they issue aeroplanes to General Hospitals.

THE TREATMENT OF INSANITY.

BY DR. HARVEY CLARE.

To those who are actively engaged in caring for mental cases I have no message, but to the outside readers of this BULLETIN who may be interested in the subject, I would like to say a few words.

This subject, the treatment of insane, has been made the talk of so many people and the basis of so many discussions, that many people have begun to think that all cases of mental disease are treated alike and that there is some standard way of taking care of these people. Insanity, not being a specific disease, but rather a legal term including many different diseases and conditions, it must necessarily follow that no treatment can be applied to all cases.

We have a great many varieties of cases treated in our hospitals. Probably the percentage of the different classes admitted work out about as follows: Dementia Præcox, 25 per cent.; Manic Depressive, 15 per cent.; Senility, 10 per cent.; Involutional Melancholia, 10 per cent.; Paretics, 10 per cent.; Exhaustion cases, 10 per cent.; Epileptics, 5 per cent.; Imbeciles, 5 per cent.; Alcoholics, 5 per cent.; other drug and toxic cases, 5 per cent.

A casual glance at this classification would prove to anyone that there is no form of treatment that is going to be a cure-all. Still every year we come across a new paper read at some association, on occupation as treatment for the insane, or continuous baths in mental hospitals, or electrotherapeutics in nervous and mental diseases.

We often see articles in newspapers and in jour-

nals on the benefits patients derive from color schemes or from music, and again, there are recognized physicians who seem to believe that all cases will be benefited if they have an operation. Every day some friend comes to us telling us that such and such a surgeon recommends that an operation be done on the patient's head, or her ovaries should be removed, or the mental condition is the result of a floating kidney, or some other equally interesting remark.

Even in our own work some men have talked so much and dreamed so much about continuous baths, that they forget everything else and put all patients in a continuous bath. Others so firmly believe in the value of occupation, that if a patient is able to walk to the farm or garden, he is at once sent out and put to work, regardless of the form of mental disease.

Who could believe that occupation or a continuous bath will have any tendency toward producing a cure in a case of paresis, or a case of epilepsy, or a case of senility; the syphilitic toxin goes on doing its work—epileptics continue having their fits and the senile goes on getting older.

The only rational way to discuss treatment of these cases is to discuss treatment of groups of cases or individual cases. First, as in any other disease, a complete examination must be made. We must have a full history; we must know what his conduct has been in the past; we must understand his environment; his disposition and his peculiarities. A mental analysis must be made and his case must be diagnosed.

Now we are in a position to see whether we are going to treat him with some hope of recovery, or merely to make his life more comfortable and to improve his present condition. We should all agree that the first essential of treatment will consist in research work. Too

little is understood about the pathology and chemistry of our cases.

Research work should be going on all of the time in every institution, no matter how poorly equipped, and any man who sees a lot of cases, can observe them, can read about them, can make notes and keep records and collect some information that will be useful at some time in helping some one else do the same work.

In every large centre, where there is a good institution, considerable attention should be given to the laboratory work, and if possible, energetic, scientific men should be engaged who could keep in touch with all the advanced work of the world. Many people say this is useless, because the results are not immediate, but even the patient immediately gets benefit from this scientific work by the increased interest that it arouses in each case.

Now, when a case is diagnosed, the treatment should be carefully considered by all the members of the staff. If he is a senile, parietic or epileptic, the treatment will consist principally of nursing. These patients do not need custodial care, so much as they need the care of a trained and experienced nurse. If the case is one of Dementia Præcox or Manic Depressive psychosis or Exhaustion psychosis, the benefits of the advice of an experienced physician is urgently demanded. This is the time it has to be decided, whether occupation will be beneficial and continuous baths will help, or whether electrotherapeutics are needed—whether amusement will be of any use in assisting to restore this patient to his former health.

Speaking generally, we have several ways of controlling excitement or restlessness, viz., continuous warm baths, hot wet packs, cold packs, exercise, warm drinks and sedatives. If any case is restless or disturbed, all of these methods have to be considered. Other cases must be referred to, and it is a matter of judgment as to what is

the best way to control this particular case of excitement. Cases of depression are usually treated by rest in bed in the fresh air, plenty of nourishment, pleasant surroundings, careful watching, massage, cool sponges, etc.

But the idea I wish to bring out is, that each individual case requires individual consideration, and any medical practitioner who recommends continuous baths, packs or exercise for any patient without carefully considering the case, is placing himself in the position of the patent medicine dealer who recommends one potion for all illnesses.

It is interesting to inquire how many men are inclined to believe that mental diseases are in some way or other associated with disorders of the sexual organs. Medical men as well as the laity get this idea.

I have known intelligent people take their sister out of the hospital, hand her over to a good surgeon and have her ovaries taken out and promptly send her back to this hospital again. I have seen a great many cases of epilepsy in which surgeons have trephined and taken out a piece of bone, but so far as we could see he had no particular reason for taking out any special piece of bone.

If a patient comes to our hospital suffering from a physical illness, such as pneumonia, typhoid fever, or tuberculosis, we try to treat him in the same way as treated by other physicians.

If he had a dislocated shoulder or a fractured rib, it is put up in the same way as it would be done in any other hospital. If he has some other physical condition that requires urgent attention, we try to have it attended to at once, but do not advise that the patient should be gone over with the idea of trying to find something that might be operated upon. A hernia that is being well supported by a truss is not going to cause any mental symptoms. The remodelling of a harelip will not change the patients' way of thinking.

If the patient has an acute or chronic appendicitis that needs attention, certainly the appendix should be taken out, or else the patient may lose his life, but it is not taken out with the idea that it is going to have any effect on his mentality.

We are constantly meeting new fads—I have gone into institutions where the rooms were painted all sorts of hideous colors—some one has said that these colors have a sedative effect. At other places they have paid musicians, who continually perform at a piano because music is said to be beneficial.

But, after all, I think that the only true treatment for a mental disease, as for all other diseases, is a rational treatment outlined after careful examination and full consideration of each individual case, and no treatment can be properly and efficiently carried out without the assistance and benefit of a good laboratory, scientific physicians and careful nursing.

FEMALE NURSES IN MALE WARDS OF
MENTAL HOSPITALS.

At a meeting of the Medico-Psychological Association in London on February 17th, Dr. George M. Robertson, physician-superintendent of the Royal Edinburgh Asylum, Morningside, and lecturer on mental diseases in the University of Edinburgh, read a paper on the employment of female nurses in the male wards of mental hospitals in Scotland. After recalling that he had opened a discussion on the subject at the annual meeting of the association ten years ago, and observing that the shortage of male attendance in asylums had again made the consideration of the plan urgent, he gave a historical sketch of the growth of opinion on the subject. Auxiliary female care had been introduced into the Gloucester Asylum in 1841 by Dr. Samuel Hitch, who employed the wives of his married charge attendants to help their husbands. In 1883 Dr. R. M. Bucke, of the London Asylum in Canada, had employed widows in the male wards with complete success. Sir Thomas Clouston, who had placed a married couple in charge of the Male Hospital at Morningside, when the husband died in 1890, appointed the widow in full charge, and placed the male attendants under her authority. The defect of the system of auxiliary female care was that the nurses were few in number, and only assisted the male attendants, the bulk of the nursing even in those wards in which they were employed being still done by the male attendants.

The first step towards the system by which a group of male patients was entirely nursed by women was taken by Dr. Turnbull in the Fife and Kinross Asylum in 1896; he placed a ward containing thirty male hospital patients entirely under the charge of female nurses by day. Supervision was exercised by the matron and the charge

nurse of the female hospital. The Scottish Commissioners realized the value of Dr. Turnbull's innovation, and on the advice of Sir John Sibbald, a similar arrangement was introduced into the Glasgow (Gartloch), Lanark, and Perth District Asylums. In 1900, Dr. Robertson said, he had placed a group of male patients at the Stirling District Asylum under the charge of female nurses by night as well as by day. The Scottish system of entire female nursing was totally different in practice from that of auxiliary female care, and all who had large experience of women nurses in male wards agreed that they were infinitely more useful if placed in sole charge of a group, and they much preferred it themselves. The desire to make use in asylums of the high standard of skill in nursing possessed by those trained in general hospitals had led to the appointment of large numbers of trained hospital nurses during the last twelve years to important positions in the Scottish asylums; for, unfortunately, men did not receive training in nursing in the general hospitals. Dr. Campbell Clark was the first to appoint, at the Kirklands Asylum, Bothwell, in 1880, a trained hospital nurse to be matron. In the following year he began the systematic teaching and training of his asylum nurses and attendants. In 1885 the Scottish division of the Medico-Psychological Association published a handbook for attendants on the insane, which was subsequently adopted by the association, and had led to the granting of the certificate for proficiency in mental nursing and to the registration of certificated mental nurses.

The first hospital nurse to work within the wards among insane patients and asylum nurses was appointed by the speaker at the Perth District Asylum in 1896. This step not only had its direct influence on ward work, but created a supply of hospital nurses specially trained for the duties of asylum matronship. So great did the demand become that three dozen of his own nurses had

received such appointments in other institutions. Nurses accustomed to attend to male patients in the general hospitals thought it the most natural thing to continue to take charge of male patients in asylums, and their presence had led to the introduction of innumerable reforms which had approximated the methods employed in the asylums to those in the hospitals, and the greater employment of women in the male wards was only one among them. The employment of female nurses in the male wards in Scotland was, in fact, only a part of a much greater ideal—that of the hospitalization of the asylum. Nursing by women was now as distinctive and firmly established a feature of the Scottish system of care for the insane as the boarding-out system. It was employed in some measure in all but two of the important asylums of the country, and in these exceptions failure to introduce it was not due to opposition to the principle but to structural difficulties. In a fourth of the asylums in Scotland, and among them some of the large ones, the matron was head of the staff on the male side as well as on the female side.

In introducing female nurses into the male wards for the first time the most reliable women on the staff should be selected. They should be experienced and should not be young. The working unit should not be less than four, and it was a great advantage to place a hospital nurse with asylum experience in charge of them. They were best adapted to manage wards containing patients confined to bed. When the patients were dressed and going about it was advisable to employ one or two trustworthy male married attendants to bathe the patients and to assist in other ways. It was not true that female nurses were only of use in the care of the sick and helpless in an asylum. They usually exercised more control over cases of mania than male attendants, and their success was due to the fact that their method was based on persuasion and not on force or compulsion. A woman

had much the same influence over an insane man not actually delirious as she had over one supposed to be in his sound mind, and it was absurd to assume that all feelings of chivalry and honour died in a man because he suffered from some derangement of the mind.

The capacity of the insane for education in good habits, while not illimitable, was very extensive, and in practice was never exhausted in large institutions. If it could be alleged of any asylum that its male wards were not a suitable place for women, then the sooner a reformation was effected the better, for it was not a condition that need continue indefinitely. Male patients were always less troublesome and excitable than female, and women found that they received more courtesy and readier obedience from men than from women. It was not necessary to pay an extra salary, for once the system was started the women were engaged as in general hospitals, simply to nurse, and it was all in the day's work whether their patients were male or female. It was doubtful whether the employment of women instead of men would mean any saving in expense, because, owing to the higher standard of hospital care sought, usually a larger number of nurses was required. In Scotland any saving had been more than counterbalanced by the increased night staff, which was proportionally much larger than that employed in English asylums and on hospital nurses for purposes of supervision, a practice now largely adopted. Lastly, it had been said that many male patients, owing to their sexual proclivities, could not be cared for by women. This was undoubtedly true, but the remedy was simple—do not place them under women; let them be cared for by men. No experienced administrator would allow a simple difficulty of this kind, with an obvious remedy, to deter him from the introduction of women nurses. Every day of the year, in every asylum in the country, a much more difficult and responsible task of an analogous nature was faithfully performed—that of dis-

tinguishing the patients who were suicidal from those who were not, and of making special arrangements for their care. To pick out patients whom it was undesirable to place under the care of women was, compared with this, an exceedingly simple matter.

Nursing the sick, the infirm, and the helpless, sane or insane, was pre-eminently woman's avocation, and Sir Thomas Clouston had summed up the situation tersely when he said that all his nurses longed to work in the hospital, whereas all his male attendants preferred outdoor work. Moreover, women were better than men at the superintendence and discharge of domestic duties. The proportion of women it was desirable to employ on the male side of an asylum was, according to the Scottish Board of Control, at least 25 per cent. of the total day staff on the male side and 15 per cent. of the night staff. These figures were considerably exceeded in several asylums, among which might be mentioned the Stirling District Asylum. It might be taken as a typical county asylum in the accommodation it provided, in its complete organization, and in the modern methods employed. It admitted over 250 patients annually, and had a resident population of over 800. Dr. R. B. Campbell, its medical superintendent, had employed for the last seven and a half years, as the speaker did for an equal period, a staff on the male side by day of which 40 per cent. consisted of women, there being three hospital nurses, including the matron. By night 27 per cent. of the staff consisted of women, including the night superintendent, who is a trained hospital nurse.

Dr. Robertson said that he did not accept the contention that female nurses were more suitable for asylums admitting parochial than for those receiving private patients. Craig House, the department of the Royal Edinburgh Asylum for private patients, was a separate mental hospital, and of the staff of 32 employed by day to attend to 100 gentlemen exactly one-half consisted of

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nurses, including in this number the lady superintendent and three matrons, and of these three were hospital nurses. At night six out of a staff of thirteen consisted of women, including the night superintendent, who was a trained hospital nurse. The proportion of women varied, and had perhaps been swelled by the war, but there was no difficulty in employing 40 per cent. of women by day and 25 per cent. by night in a private asylum.

Who Is Insane? By STEPHEN SMITH, R.M., M.D., LL.D., Commissioner of Lunacy for State of New York from 1882-1888. McMillan Company. Price, \$1.25.

This interesting book is worthy of wide circulation among those who are interested in the subject of mental diseases. From a long experience the author traces the progress of the care and treatment of the insane from the period when he took office in the New York State Board in 1882 up to the present time. He is still hopeful of much greater advances, based upon the present method of research and treatment which will reveal a much wider scope for the liberty, usefulness and self-support of those who formerly had been adjudged insane and given over to custodial care. This book is not written in technical language, and may be fully grasped by the popular as well as the scientific reader.

A System for Case-taking. By GEORGE WILLIAM ROSS, M.A., M.B., Toronto, M.R.C.P., London; Demonstrator in Clinical Medicine, University of Toronto, and JULIAN LONDON, B.A., M.B., Toronto, M.R.C.S. England, L.R.C.P. London; Assistant in Clinical Medicine, University of Toronto. The MacMillan Company, Toronto.

In this book of seventy pages, the authors present a clear and compact treatise of a System for Case-taking. They divide the history under nine headings: General Registration, Complaint, Present Illness, Personal His-

tory, Family History, Initial Observation, General Examination, Interrogation and Investigation of Special Systems. Each of these topics are subdivided with a résumé of all the important points, systematically given below, while on the opposite page each is fully discussed.

I feel that this treatise will be of great value to every physician and student.

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